



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FSAS DBA LONE STAR ANESTHESIA GROUP
808 RUSSELL PALMER ROAD SUITE 151
KINGWOOD TX 77339

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-3257-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There was a precert on file with the surgeon. As anesthesiologist we do not obtain precertification."

Requestor's Position Summary in Letter dated April 18, 2011: "The above mentioned claim was denied for no precertification. The facility, First Surgical Woodlands, did obtain an authorization and we are asking that the authorization be applied to our claim." "We preformed anesthesia services for the patient's procedure but did not see the patient prior to surgery. As anesthesiologists we do not obtain authorizations but the facility or surgeon does. The facility did obtain an authorization # 1072516F0 and we are asking for you to apply that authorization to our claim and reprocess it."

Amount in Dispute: \$550.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 3, 2011	CPT CODE 01830-AA	\$550.00	\$272.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, 33 TexReg 626, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 11, 2011

- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- AA-Anesthesia services performed personally by anesthesiologist.
- PA-Prior Allowed.
- W1-Workers compensation state fee schedule adjustment.

Refer to Workers' Compensation jurisdiction disclaimer; paragraph (36) on reverse.

NOTE: Void check per adjuster.

Explanation of benefits dated April 21, 2011

- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- AA-Anesthesia services performed personally by anesthesiologist.
- PA-Prior Allowed.
- W1-Workers compensation state fee schedule adjustment.

Refer to Workers' Compensation jurisdiction disclaimer; paragraph (36) on reverse.

NOTE: No preauthorization for surgery.

Issues

1. Does a preauthorization issue exist?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the dispute services based upon "No preauthorization for surgery."

28 Texas Administrative Code §134.600(p)(2) states "Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

The requestor states in the position summary that "The facility did obtain an authorization # 1072516F0 and we are asking for you to apply that authorization to our claim and reprocess it."

On May 27, 2011, the respondent's representative acknowledged receipt of the notification of this dispute.

The respondent did not submit documentation to support the denial of services based upon lack of preauthorization per 28 Texas Administrative Code §134.600(p)(2). Therefore, the Division determined that the denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. CPT code 01830 is defined as "Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified".

The requestor appended modifier AA to delineate that the "Anesthesia services performed personally by anesthesiologist".

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

28 Texas Administrative Code §134.203(c)(1) states, "...To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification...For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology,

Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$53.68...”

To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance

The Division reviewed the submitted anesthesia report and finds the anesthesia was started at 1030 and ended at 1100, for a total of 30 minutes. Per Trailblazers Health Enterprises, LLC 2011 Anesthesia Manual “One time unit will be allowed for each 15-minute interval, or fraction thereof, starting from the time the physician begins to prepare the patient for induction and ending when the patient may safely be placed under post-operative supervision and the physician is no longer in personal attendance. Actual time units will be paid; do not round.” Therefore, 30 minutes ÷ 15 minutes = 2 Time units.

28 Texas Administrative Code §134.203(b)(1) the base unit for CPT code 01830 is 3.

The 2011 DWC conversion factor is 54.54.

The MAR for CPT code 01830-AA is: 3 (Base Unit) + 2 (Time Unit) = 5 X \$54.54 (conversion factor) = \$272.70 less previously paid by the respondent of \$0.00 = \$272.70.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports reimbursement sought by the requestor. The Division concludes that the requestor failed to support its position that reimbursement is due. As a result, the amount ordered is \$272.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$272.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

5/16/2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.